		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027532

Facility Name: Manorcare at Normal

Address: 510 Broadway (Number) Normal (City) 61761 (Zip Code)

County: McLean

Telephone Number: (309) 452-4406 **Fax #** (309) 454-7908

HFS ID Number: 520886946006

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany, CPA **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/04 to 05/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President of Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	109	39,785	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	109	39,785	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	709	9,643	12,793	23,145	8
9	SNF/PED					9
10	ICF	7,900	3,878	388	12,166	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,609	13,521	13,181	35,311	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.75%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/ 01 /81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 97 and days of care provided 10,562

Medicare Intermediary Care First of Maryland, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/05 Fiscal Year: 05/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare at Normal # 0027532 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	162,315	20,240	55,896	238,451	2,264	240,715		240,715			1
2	Food Purchase		199,977		199,977		199,977	(2,006)	197,971			2
3	Housekeeping	121,337	27,189	6,000	154,526		154,526		154,526			3
4	Laundry	20,577	15,839	1,767	38,183		38,183		38,183			4
5	Heat and Other Utilities			106,741	106,741	5,224	111,965	(581)	111,384			5
6	Maintenance	40,356	15,977	56,478	112,811		112,811		112,811			6
7	Other (specify):* Medical Waste			1,229	1,229		1,229		1,229			7
8	**TOTAL General Services**	344,585	279,222	228,111	851,918	7,488	859,406	(2,587)	856,819			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,719,845	138,709	50,799	1,909,353	38,622	1,947,975	(5,100)	1,942,875			10
10a	Therapy	303,115	5,915	247,790	556,820		556,820		556,820			10a
11	Activities	72,080	3,865	1,727	77,672		77,672		77,672			11
12	Social Services	111,228	154	1,402	112,784		112,784		112,784			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,206,268	148,643	307,718	2,662,629	38,622	2,701,251	(5,100)	2,696,151			16
	C. General Administration											
17	Administrative	111,864		347,797	459,661	(141,595)	318,066		318,066			17
18	Directors Fees											18
19	Professional Services			914	914		914	(914)				19
20	Dues, Fees, Subscriptions & Promotions			56,377	56,377		56,377	(37,920)	18,457			20
21	Clerical & General Office Expenses	156,352	40,631	330,679	527,662		527,662	(296,605)	231,057			21
22	Employee Benefits & Payroll Taxes			605,012	605,012	35,507	640,519		640,519			22
23	Inservice Training & Education			2,641	2,641		2,641		2,641			23
24	Travel and Seminar			12,631	12,631		12,631		12,631			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			117,264	117,264		117,264		117,264			26
27	Other (specify):*											27
28	**TOTAL General Administration**	268,216	40,631	1,473,315	1,782,162	(106,088)	1,676,074	(335,439)	1,340,635			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,819,069	468,496	2,009,144	5,296,709	(59,978)	5,236,731	(343,126)	4,893,605			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare at Normal #0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			292,375	292,375	15,443	307,818		307,818			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			61,476	61,476	44,535	106,011	(646)	105,365			32
33	Real Estate Taxes			54,436	54,436		54,436	48,924	103,360			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,037	35,037		35,037		35,037			35
36	Other (specify):*											36
37	**TOTAL Ownership**			443,324	443,324	59,978	503,302	48,278	551,580			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		348,296	83,716	432,012		432,012		432,012			39
40	Barber and Beauty Shops			14,578	14,578		14,578		14,578			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			59,679	59,679		59,679		59,679			42
43	Other (specify):* **Therapy Drugs**		14,595		14,595		14,595		14,595			43
44	**TOTAL Special Cost Centers**		362,891	157,973	520,864		520,864		520,864			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,819,069	831,387	2,610,441	6,260,897		6,260,897	(294,848)	5,966,049			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare at Normal # 0027532 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,006)	2		4
5	Telephone, TV & Radio in Resident Rooms	(581)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(646)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(5,100)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,853)	21		18
19	Entertainment				19
20	Contributions	(205)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(914)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(288,415)	21		24
25	Fund Raising, Advertising and Promotional	(37,920)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	48,924	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,132)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (294,848)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (294,848)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Manorcare at Normal

ID# 0027532

Report Period Beginning: 06/01/04

Ending: 05/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Customer Reimbursement	$ (6,132)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,132)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Normal # 0027532 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,006)	0	0	0	0	0	0	0	0	0	0	(2,006)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(581)	0	0	0	0	0	0	0	0	0	0	(581)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,587)	0	0	0	0	0	0	0	0	0	0	(2,587)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(5,100)	0	0	0	0	0	0	0	0	0	0	(5,100)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(5,100)	0	0	0	0	0	0	0	0	0	0	(5,100)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(914)	0	0	0	0	0	0	0	0	0	0	(914)	19
20	Fees, Subscriptions & Promotions	(37,920)	0	0	0	0	0	0	0	0	0	0	(37,920)	20
21	Clerical & General Office Expenses	(296,605)	0	0	0	0	0	0	0	0	0	0	(296,605)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(335,439)	0	0	0	0	0	0	0	0	0	0	(335,439)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(343,126)	0	0	0	0	0	0	0	0	0	0	(343,126)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Manorcare at Normal** **#** **0027532** **Report Period Beginning:** **06/01/04** **Ending:** **05/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(646)	0	0	0	0	0	0	0	0	0	0	(646)	32
33	Real Estate Taxes	48,924	0	0	0	0	0	0	0	0	0	0	48,924	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	48,278	0	0	0	0	0	0	0	0	0	0	48,278	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(294,848)	0	0	0	0	0	0	0	0	0	0	(294,848)	45

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
	100	Health Care & Retirement Corporation	Toledo, OH			
Manor Care, Inc		of America				
		(See H.O. Cost Report)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See		$ 347,797	HCR Manor Care, Inc	100.00%	$ 347,797	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	23,443	Heartland Management Services	100.00%	23,443		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 371,240			$ 371,240	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc
Street Address: 33 North Summit St
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	1,043,233	571,891	6,140,763	2,264	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	223,707		6,140,763	581	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,139,042		6,140,763	4,643	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	12,987,607	8,226,246	6,140,763	33,733	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,252,260	1,199,059	6,140,763	4,889	6
7	17	General & Admin - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	16,611,639	15,056,893	6,140,763	43,146	7
8	17	General & Admin - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	75,121,310	43,509,256	6,140,763	163,056	8
9	22	Employees Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	3,924,545		6,140,763	10,193	9
10	22	Employees Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	11,662,215		6,140,763	25,314	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac			6,140,763	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	7,114,804		6,140,763	15,443	12
13										13
14	32	Interest				10,002,527			44,535	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,082,889	$ 68,563,345		$ 347,797	25

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Conv Sub Debentures		X	Facility			$ 684,665	$ 684,665			$ 44,535	1
2	National City Bank, Trustee						983,699	983,699			61,476	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8								Interest Income			(646)	8
9	TOTAL Facility Related						$ 1,668,364	$ 1,668,364			$ 105,365	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,668,364	$ 1,668,364			$ 105,365	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Manorcare at Normal **#** 0027532 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	10,417	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	59,341	2
3. Under or (over) accrual (line 2 minus line 1).	$	48,924	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	54,436	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	103,360	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	37,569	8
	2001	41,693	9
	2002	60,358	10
	2003	42,658	11
	2004	54,436	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare at Normal COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0027532

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-28-479-009	See Attached	$ 27,218.05	$ 27,218.05
2.	14-28-479-009	See Attached	$ 27,218.05	$ 27,218.05
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,436.10	$ 54,436.10

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,079 B. General Construction Type: Exterior Masonry Frame Steel,Fire Resistant Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1971	$ 58,339	1
2			1993 & 2001	115,287	2
3	TOTALS			$ 173,626	3

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1971	1962	$ 506,817	$ 28,738		$ 28,738	$	$ 1,155,035	4
5	9			1994	497,564						5
6	10			2001	588,325						6
7											7
8											8
	Improvement Type**										
9	Building Improvements (Current Year Depreciation)					151,444		151,444		1,678,870	9
10				1979	60,522						10
11				1980	317,478						11
12				1981	50,351						12
13				1982	21,867						13
14				1984	16,946						14
15				1985	26,268						15
16				1986	18,155						16
17				1987	42,286						17
18	RETIREMENTS			1987	(29,830)						18
19				1988	207,264						19
20				1989	134,621						20
21				1990	46,332						21
22				1991	15,386						22
23				1992	57,357						23
24	RETIREMENTS			1992	(3,110)						24
25				1993	44,829						25
26				1994	137,130						26
27				1995	72,481						27
28	RENOVATIONS-PATIENT ROOMS			1996	22,684						28
29	CARPET/TILE & INSTALLATION			1996	4,392						29
30	CAPITALIZED LABOR			1996	7,272						30
31	WALLVINYL/DRYWALL			1996	5,194						31
32	SIGNS/BOARDS			1996	1,730						32
33	INSTALL GRID/PANELS			1996	4,402						33
34	CONCRETE WALK/RAMP			1996	2,850						34
35	CABINETS			1996	1,087						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CARPETING	1996	$ 9,845	$		$	$	$	37
38	ROOFING	1996	24,474						38
39	ELECTRICAL/LIGHTING	1996	2,159						39
40	WALLCOVERINGS	1996	5,910						40
41	SIGNS/CORNERGUARDS/CHAIR RAIL	1996	2,433						41
42	INSTALL SHOWER TILE	1996	2,656						42
43	REPAIR COMPRESSOR	1996	900						43
44	CONCRETE WALK	1996	1,053						44
45	CR5/31/99 AUDIT ADJ - CAPITAL	1996	(7,272)						45
46	PAINTING & DECORATING	1997	15,688						46
47	ROOF REPLACEMENT	1997	3,345						47
48	WALLCOVERINGS	1997	1,788						48
49	TILE & INSTALLATION	1997	2,686						49
50	CARPET	1997	1,547						50
51	INSTALL COMPRESSOR	1997	2,583						51
52	ROOF WORK	1997	51,370						52
53	WALK-IN COOLER/FREEZER	1997	9,466						53
54	ALLOC. FAC. PLAN	1997	2,758						54
55	PLUMBING/BATHROOM WORK	1997	1,226						55
56	ELECTRICAL	1997	2,416						56
57	CR5/31/99 AUDIT ADJ - CAPITAL	1997	(2,758)						57
58	CR5/31/99 AUDIT ADJ - CAPITAL	1998	(1,702)						58
59	FINISH/STUD	1998	4,865						59
60	PAINTING/WALLCOVERINGS	1998	8,175						60
61	CARPETING	1998	6,460						61
62	PLUMBING	1998	1,456						62
63	ROOFING	1998	2,170						63
64	DOORS/WINDOWS/CASEWORK	1998	9,884						64
65	ELECTRICAL	1998	5,360						65
66	FLOORING/CEILING/COVE BASE	1998	13,283						66
67	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	1,298						67
68	CORPORATE OVERHEAD-PATIENT ROOMS	1998	1,702						68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,065,874	$ 180,182		$ 180,182	$	$ 2,833,905	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,065,874	$ 180,182		$ 180,182	$	$ 2,833,905	1
2	FURNISH & INSTALL STEEL DOORS	1998	2,439						2
3	MILLWORK	1998	1,166						3
4	INSTALL DUCTS	1998	327						4
5	REWORK FIRE/SMOKE DAMPERS	1998	632						5
6	RENOVATE PATIENT ROOMS	1998	5,233						6
7	WALKWAY	1998	7,267						7
8	ELECTRICAL	1998	8,111						8
9	ROOFING	1998	8,485						9
10	SIGNAGE	1998	13,529						10
11	DOORS/WINDOWS	1998	1,773						11
12	GENERAL CONTRACTOR FEES-PATIENT ROOMS	1998	2,507						12
13	MASONRY	1998	3,700						13
14	PAINTING/WALLCOVER	1998	251						14
15	FLOORING	1998	458						15
16	RENOVATE PATIENT ROOMS	1998	(2,520)						16
17	GAZEBO	1998	2,495						17
18	FLOORS	1999	2,990						18
19	DOORS	1999	18,097						19
20	FENCING	1999	4,343						20
21	SIDEWALK	1999	3,719						21
22	FIRE SPRINKLER	1999	6,270						22
23	WATER HEATER	1999	7,717						23
24	FLOORS	2000	830						24
25	DOORS	2000	11,081						25
26	RENOVATION-ARCADIA ADDTN	2000	5,000						26
27	CONCRETE	2000	1,685						27
28	CARPENTRY	2000	3,179						28
29	DRYWALL / FINISHES	2000	15,397						29
30	CEILING / FLOORING	2000	5,680						30
31	CARPETING & PADS	2000	7,167						31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,214,881	$ 180,182		$ 180,182	$	$ 2,833,905	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,214,881	$ 180,182		$ 180,182	$	$ 2,833,905	1
2	PAINTING	2000	28,868						2
3	WALLCOVERING	2000	7,060						3
4	ELECTRICAL	2000	12,505						4
5	GENERAL OVERHEAD & MISC-ARCADIA ADDTN	2000	25,528						5
6	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(25,528)						6
7	INTEREST ON CONSTRUCTION-ARCADIA ADDITION	2000	5,447						7
8	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(5,447)						8
9	OVERHEAD COST-ARCADIA ADDITION	2000	43,193						9
10	5/31/03 Audit Adjustment (See IDPH Pg.12 Schedule)	2000	(43,193)						10
11	WATER HEATER	2001	9,350						11
12	8 REPLACEMENT WINDOWS	2001	5,812						12
13	MIXING VALVE	2001	3,397						13
14	CARPET & VWC	2001	24,531						14
15	SOIL & CONCRETE TESTING	2001	2,905						15
16	WATER & SEWER, PERMIT FEES	2001	14,582						16
17	SITEWORK	2001	74,254						17
18	LANDSCAPING	2001	2,270						18
19	ADDITIONAL COST SITEWORK	2001	371						19
20	FLOORING BY GREASE TRAP	2002	753						20
21	FLOORING	2002	5,415						21
22	ADDITIONAL ARCHITECTURE ENG.	2002	65						22
23	ARCHITECTURE ENGINEERING	2002	350						23
24	ARCHITECTURE ENGINEERING	2002	2,993						24
25	FRONT HALL & OFFICE WALLS/FLOORS	2002	7,395						25
26	FRONT HALL & OFFICE WALLS/FLOORS	2002	39,302						26
27	FRONT HALL & OFFICE WALLS/FLOORS	2002	13,311						27
28	DIETARY HVAC	2002	82,214						28
29	SMOKE SHELTER	2002	3,540						29
30	ALUMINUM SHELTER	2002	5,225						30
31	SIDEWALK	2002	2,375						31
32	FENCE	2002	975						32
33	RETROACTIVE ADDITION	2002	(10)						33
34	TOTAL (lines 1 thru 33)		$ 3,564,690	$ 180,182		$ 180,182	$	$ 2,833,905	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,564,690	$ 180,182		$ 180,182	$	$ 2,833,905	1
2	LANDSCAPING	2003	7,887						2
3	DEVELOPERS COST - OVERHEAD	2003	10,184						3
4	INTEREST ON CONSTRUCTION	2003	722						4
5	CARPENTRY	2003	3,460						5
6	FLOORING	2003	7,040						6
7	PAINTING	2003	33,211						7
8	WALLCOVERING	2003	6,434						8
9	HVAC	2003	3,587						9
10	VWC	2003	754						10
11	HANDRAILS & INSTALLATION	2003	2,300						11
12	VWC	2004	922						12
13	BORDER	2004	56						13
14	PAINT, VWC & BORDER	2004	1,300						14
15	CABINETS AND COUNTERTOPS	2004	5,671						15
16	FLOORING	2004	2,288						16
17	FLOORING	2004	7,170						17
18	PAINT & VWC	2004	7,200						18
19	CARPET	2004	868						19
20	OVERLAY ASPHALT PARKING LOT	2004	9,662						20
21	PARKING LOT CONSTRUCTION AND PAVING	2005	55,622						21
22	PAINT & VINYL WALL COVERING	2004	1,189						22
23	PAINT & VINYL WALL COVERING	2004	3,497						23
24	VINYL WALL COVERING	2004	219						24
25	DOOR WITH LOCK	2004	3,461						25
26	EXIT PANEL	2003	1,995						26
27	VINYL COVERED TILE	2004	640						27
28	PAINTING	2004	1,450						28
29	VINYL WALL COVERING	2004	432						29
30	ENGINEERING, OVERHEAD & INTEREST	2004	43,667						30
31	ELECTRICAL WORK	2004	30,627						31
32	VINYL WALL COVERING	2004	56						32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,818,261	$ 180,182		$ 180,182	$	$ 2,833,905	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,818,261	$ 180,182		$ 180,182	$	$ 2,833,905	1
2	VINYL COVERED TILE AND COVE BASE	2004	2,175						2
3	ADJUST ASSET #1851 (VINYL WALL COVERING)	2004	(56)						3
4	ELECTRICAL WORK	2004	4,342						4
5	ELECTRICAL WORK	2004	8,455						5
6	ENGINEERING COST, OVERHEAD & INTEREST	2005	9,557						6
7	VINYL WALL COVERING	2005	1,279						7
8	VINYL WALL COVERING	2005	1,279						8
9	13 PHONE LINES & JACKS	2005	3,520						9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,848,810	$ 180,182		$ 180,182	$	$ 2,833,905	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,212,688	$ 112,193	$ 112,193	$		$ 747,648	71
72	Current Year Purchases	167,962						72
73	Fully Depreciated Assets	(2,669)						73
74	Home Office Allocation			15,443	15,443			74
75	TOTALS	$ 1,377,981	$ 112,193	$ 127,636	$ 15,443		$ 747,648	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,400,417	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 292,375	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 307,818	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 15,443	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,581,553	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	$ 21,299	92
93			93
94			94
95		$ 21,299	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 35,037 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3173 hrs	$ 79,713	1,887	$ 47,181	$ 2,596	5,060	$ 129,490	1
2	Licensed Speech and Language Development Therapist	10a	1417 hrs	35,590	881	22,035	156	2,298	57,781	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	7477 hrs	187,812	7,122	178,056	3,163	14,599	369,031	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				348,296		348,296	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab, X-Ray, Inhal	10,Col 3, 39				84,234			84,234	13
14	TOTAL			$ 303,115	9,890	$ 331,506	$ 354,211	21,957	$ 988,832	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Normal # 0027532 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,983	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (582,944))	1,179,331		3
4	Supply Inventory (priced at)	38,815		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,926		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,229,055	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	173,626		13
14	Buildings, at Historical Cost	3,848,811		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,377,980		16
17	Accumulated Depreciation (book methods)	(3,581,553)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	21,299		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,840,163	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,069,218	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 61,125	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	220,176		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,436		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	56,369		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 392,106	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	983,699		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	11,744		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 995,443	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,387,549	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,681,669	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,069,218	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,436,153	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,436,153	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	771,905	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 771,905	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(526,389)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (526,389)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,681,669	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,127,744	1
2	Discounts and Allowances for all Levels	(893,315)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,234,429	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,407,341	6
7	Oxygen	13,392	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,420,733	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,312	12
13	Barber and Beauty Care	15,761	13
14	Non-Patient Meals	38	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	346,108	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,945	19
20	Radiology and X-Ray		20
21	Other Medical Services	830	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 376,994	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	462	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 462	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	184	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 184	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,032,802	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	851,918	31
32	Health Care	2,662,629	32
33	General Administration	1,782,162	33
	B. Capital Expense		
34	Ownership	443,324	34
	C. Ancillary Expense		
35	Special Cost Centers	520,864	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,260,897	40
41	**Income before Income Taxes (line 30 minus line 40)****	771,905	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 771,905	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,676	1,812	$ 50,927	$ 28.11	1
2	Assistant Director of Nursing	3,282	3,547	70,436	19.86	2
3	Registered Nurses	10,999	11,889	263,887	22.20	3
4	Licensed Practical Nurses	24,758	26,761	486,946	18.20	4
5	CNAs & Orderlies	70,259	75,942	826,062	10.88	5
6	CNA Trainees					6
7	Licensed Therapist	11,364	12,067	303,115	25.12	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,833	7,386	72,080	9.76	10
11	Social Service Workers	5,928	6,399	111,228	17.38	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,248	18,673	162,315	8.69	15
16	Dishwashers					16
17	Maintenance Workers	2,132	2,306	40,356	17.50	17
18	Housekeepers	13,440	14,526	121,337	8.35	18
19	Laundry	2,435	2,652	20,577	7.76	19
20	Administrator	4,005	4,005	102,106	25.49	20
21	Assistant Administrator	472	472	9,758	20.67	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,413	11,808	156,352	13.24	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,928	2,082	21,587	10.37	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,172	202,327	$ 2,819,069 *	$ 13.93	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	6,000	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 6,000		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Douglas Daudelin	Administrator	0	$ 102,106
Debra Porter	Assist Admin	0	9,758
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 111,864

B. Administrative - Other

Description	Amount
Home Office	$ 347,797
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 347,797

C. Professional Services

Vendor/Payee	Type	Amount
Allison & Mosby-Scott Law Office	Legal Fees	$ 914
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 914

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,689
Unemployment Compensation Insurance	54,186
FICA Taxes	200,889
Employee Health Insurance	247,976
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	7,387
401K	5,916
Employee Uniforms	5,729
Payroll Overhead Allocated	0
Tuition Program	240
Home Office Allocation	35,507
TOTAL (agree to Schedule V, line 22, col.8)	$ 640,519

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,584
Advertising: Employee Recruitment	2,844
Health Care Worker Background Check	2,837
(Indicate # of checks performed 142)	
Dues & Subscriptions	3,146
Association Dues	5,313
Advertising	40,598
Public Relations	55
Less: Non-Allowable Association Dues	(1,715)
Less: Public Relations Expense	(55)
Non-allowable advertising	(36,150)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,457

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	12,631
Includes travel expense to the Home Office in Toledo, OH for regional meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,631

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare at Normal # 0027532 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Manorcare at Normal # 0027532 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $5,313**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $ 1,715**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **44,079** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **59,679**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(38)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.